WMIP QUESTIONS AND ANSWERS
REPORT 1, May 3, 2004

Snohomish County providers and health-care representatives sent several pages of questions about the WMIP project to DSHS in late April. This is the first in a series of reports addressing those concerns. The questions are numbered consecutively, but are being answered as quickly as possible. Additional answers will be posted on the Web page as they are completed.

Questions submitted to DSHS by Snohomish County April 21, 2004

1. What will reimbursement rates be for mental health and chemical dependency providers?

Answer: As with all DSHS managed care contracts, these rates are set by the managed care contractor and reflect the actuarial relationships between the client population and the services they will require as well as the contractual relationship between providers and the plan. Managed Care Organizations (MCOs) must meet DSHS contract requirements within the capitated rate amount. But because DSHS does not control rates paid to providers by MCOs, it would not be possible to otherwise predict these rates or set them in advance of the contractor's review of these factors. The work of setting these rates will get under way after the contractor is selected.

2. How much money will leave the system as profit and/or administrative overhead?

Answer: Neither profit nor administrative overhead can be determined until after the program has been implemented. A similar question was posted to DSHS at a January 27, 2004, meeting in Snohomish County, asking the predicted proportion of the capitation rate that will be spent on managed care administration? Where will this money come from? CMS evaluates and approves Medicaid managed care rates, including the proportion spent on administration. CMS considers 15% to be an acceptable administrative rate, as a rule of thumb, but will only approve administration costs that are reasonable and documented. In addition, administrative costs must be directly related to services in the Medicaid State Plan. While some managed care plans in Washington do not allocate 15% to administration, in a start-up program like WMIP it would be expected that plans devote at least 15% of the funding to administration. "Administration" in this context would include care coordination aspects of screening, assessment, care planning, coordination, referral and authorization of services, as well as assessment, management, and improvement of the quality of care and services, provider credentialing, client education and enrollment activities, assurance of member rights and responsibilities, a complaint and grievance system, and many other activities which are not provided under the fee-for-service system. The money comes from cost savings related to reducing unnecessary services, such as emergency room use, avoidable hospital stays, eliminating duplicate prescription drug use, etc.

3. How will consumers, advocates and family members meaningfully participate at the policy level?

Answer: There are currently a number of avenues for consumers, advocates and family members to participate in the WMIP decision-making processes, including the WMIP Advisory Committee, still in the development phase, the Mental Health Division's Planning and Advisory Council, and the Title XIX Committee, which is an advisory body to DSHS.

4. DSHS states that they will monitor adverse selection.

a. How will this be monitored?

Answer: DSHS actuaries at Milliman USA will conduct a retroactive analysis of encounter and claims data to check for adverse selection. Additionally, DSHS will review MCO encounter data, which is submitted quarterly, and share information with the Community Advisory Committee on findings.

b. How will it be reported to the RSN?

Answer: Any reporting and/or project updates will be shared with the Snohomish County Community Advisory Committee which is in the process of being developed. Membership on the committee has been extended to a RSN representative.

c. How will WMIP protect against adverse selections?

Answer: DSHS will review and approve all marketing materials used by the WMIP contracted MCO; will review and approve the MCO's formulary and evaluate network adequacy prior to program implementation. Ongoing program monitoring will include regular meetings with the MCO and the Community Advisory Committee, the MCO and DSHS complaints processes and community outreach.

7. How does the Allen lawsuit fit into the WMIP pilot?

***Answer*:** The same requirements that currently apply under the Allen decision (i.e., timely release from hospital settings into less restrictive treatment options) will apply to the WMIP.

9. How will WMIP meet the expectation that outpatient mental health providers be first responders to crises involving enrolled consumers?

Answer: The system currently in place (crisis line, police, Community Designated Mental Health Professional) will remain as it is now. The WMIP contractor must also be prepared with an internal crisis response system to respond to enrollees who call the plan instead of the community crisis toll-free number.

11. What specific services are included in, and excluded from, the Mental Health and Substance Abuse treatment benefit?

Answer: Covered Substance Abuse treatment services are described in Section 11.6 of the draft WMIP contract. Covered Mental Health services are described in Attachment 2 and will be incorporated in the contract.

12. DSHS states the WMIP plan will only be responsible for outpatient mental health.

a. Is there a final list of service modalities provided to the RSN and WMIP contract(s)?

Answer: Please see the answer to question number 11.

b. Has the RFP been changed to reflect just mental health outpatient services with further definitions?

Answer: Yes.

13. DSHS states that monitoring and evaluation will need to occur in order to guard against cost shifting from outpatient to inpatient service utilization:

a. How will this be accomplished and how often will the NSMHA receive these reports?

Answer: DSHS will use quarterly encounter data submitted by the plan to evaluate utilization and compare to historical data. Evaluation results will be shared with the Snohomish County Community Advisory Committee which is in the process of being developed. Membership on the committee has been extended to a RSN representative.

b. How will the volunteers that were recommended by MAA/MHD be chosen and from which stakeholder groups?

Answer: MAA/MHD has not "recommended" nor "chosen" any volunteers to be on the stakeholder groups, other than internal staff with the required expertise. Sign-up sheets for the three sub-committees were brought to numerous meetings, including the two public events on January 26th and February 17th. Attendees were asked to "volunteer" by signing up at those meetings. Anyone who signed up to be a member of the three sub-committees is considered a member of that committee. DSHS has also requested that the county recommend appropriate participants for the stakeholder groups.

14. DSHS states the rural areas in Snohomish County are currently underserved in the present system and WMIP has a greater ability to serve those needs. How will the WMIP incorporate rural services for mental health?

Answer: Molina Healthcare will incorporate rural service areas through their contract with Compass Health, the only Mental Health Network in Snohomish County. Compass has addressed the rural service area issue by locating clinics in Monroe, Arlington,

Smokey Point, Snohomish and most recently Marysville which are away from the population centers of Everett/Edmonds. These fully staffed clinics are more suited to the needs of the rural populations that surround these locations and provide access to coverage to remote county locations of 30 miles or less.

Molina Healthcare's Care Coordination Teams will enable the early identification of health needs and solutions and work to reduce barriers to health care this population has traditionally experienced.

15. DSHS states there will be no duplication of service and administrative functions. Is there a list of services and administrative functions for the WMIP provider?

***Answer*:** DSHS expects the WMIP to REDUCE duplication of administrative functions across service areas that currently operate on parallel tracks, and increase the level of service coordination for WMIP enrollees. The WMIP contract contains the services and administrative functions that the contractor will be expected to perform.

16. DSHS states WMIP contractors will be required to meet or exceed state mandates as defined in WAC. How will this increase access if criteria are the same?

Answer: Any DSHS contractor can exceed mandates or contractual requirements without incurring additional costs – the WMIP contractor may choose to exceed minimum criteria described in WAC.

20. DSHS states The Access to Care Standards is a reflection of state law RCW 71.24.035 (5) (b), which requires mental health dollars be spent on persons with the highest need first. Then they state; WMIP contractors may be able to provide services to Medicaid clients with less serious mental health needs using the projected savings in medical care.

a. This is very unclear and who will monitor savings and how they be will spent on the less serious mentally ill?

Answer: Research has shown that the provision of substance abuse treatment and mental health services can significantly reduce medical costs. The WMIP contractor will be able to use these savings to increase substance abuse and mental health treatment penetration rates above their current levels. DSHS will monitor the effectiveness of WMIP in reducing medical costs and increasing mental health and substance abuse treatment penetration rates.

b. What if no savings are realized?

Answer: A risk-based managed care contract requires that contracted services be provided whether the cost is greater or less than the capitation. These services include

regular access to primary care and mental health services, as well as quality improvement activities required by the contract. We expect medical savings to be realized and mental health and substance abuse treatment penetration rates to increase.

23. What are the specific steps DSHS plans to take to assure there will be no degradation in existing services before implementing WMIP?

Answer: Community interest and feedback have been an important part of WMIP planning and development from the start. DSHS believes that the state and the community need to work in coordination to assure no degradation of services occurs. That is an important reason for the formation of a Snohomish County Community Advisory Committee this spring. The proposed charge (still in draft form), says: "To consult and coordinate with local elected officials, providers, and community groups and to monitor improvements in client outcomes to prevent any degradation in existing services as a result of implementing WMIP." An organizational meeting for the new committee has been set up for May 17, in order to continue this important work.

24. Will stratification be used in an effort to determine if the WMIP population differs in its mental health needs from the remaining population, and if so, will payments be structured appropriately in order to ensure that the RSN is not left caring for population with the greatest needs, while no longer being able to spread the risk over a population which includes those with less needs?

Answer*:* We will consider incorporating a risk-adjustment process for the mental health component of the WMIP capitation if there is substantial selection bias in enrollment.

28. What incentive does a for-profit health care provider have to treat the mentally ill under the WMIP program? If they do not provide appropriate outpatient care, do they have to pay for the crisis and inpatient care?

***Answer*:** If the "for-profit" company desires to manage its resources wisely, and meet contract requirements in service provision and quality standards, it will appropriately manage its enrollees' care in all areas of the contract. Both DSHS and the Snohomish County Advisory Committee will be monitoring WMIP enrollees' access to outpatient mental health services and will respond appropriately.

29. There has been a statement made by the federal government in articles published by the Associated Press*: "The federal government's own projections are that private managed care plans will cost taxpayers more than traditional Medicare for the foreseeable future" (see http://www.cbsnews.com/stories/2004/03/23/politics/main608201.shtml).* If the federal government is projecting that private managed care will cost more, how does the state government project that this program will cost less?

Answer: The statement is a little out of context and actually refers to a new entity being created under the federal Medicare-drug law. As such, it does not really apply to

Washington Medicaid's long experience with managed care contractors who operate now at a savings compared to fee-for-service programs. More importantly, the WMIP project is focused first on quality of care and access improvements, not savings. The RFP already has discounted WMIP rates from fee for service costs and does not require any additional savings. Down the road, WMIP planners believe further efficiencies and savings will be possible, but they are not our initial priority.

30. Why didn't the state add start-up (seed money) in the design of the WMIP project? The examples they sited while supporting WMIP all had start up funding as a base? Is the state counting on the diversion of the mental health dollars to become the seed money (start-up funds) for the WMIP?

Answer: DSHS does not pay for start up costs for a managed care program. These costs are considered a cost of doing business for the MCO. New Mexico's integrated medical/mental health managed care program did not have start up funding. We expect MEDICAL savings will be used to increase mental health and substance abuse treatment penetration rates.

33. We need to see a detailed timeline for WMIP implementation.

Answer: DSHS has provided Snohomish County Human Services staff with a timeline as part of a Communications Plan (also posted on the WMIP Web site). We will continue to update and add detail as part of the communications plan. We hope to make progress on this at the next meeting.

34. What criteria will MAA use to judge the adequacy of the contracted provider network put together by the selected WMIP MCO?

***Answer*:** Please see Question No. 9 on the RFP Technical and Management Evaluation for network adequacy standards, and the network adequacy standards in Section 4 of the draft WMIP contract. Please note that, should an enrollee require services from a provider who is not in the contracted network, for example, a specialty service, the plan is required to cover the service by the non-participating provider.

35. What is our access to the steering committees and other planning circles?

Answer: Please see the Communication Plan to see how these committees relate to one another. The new community advisory committee being formed to keep project staff, providers and stakeholders in touch with each other throughout coming months will guarantee community health-care representatives quick and easy access to DSHS staff and the planning process.

38. What steps are being taken to address the diverse language needs of the population to be served, in explaining the pilot and how to opt out? Who and how will we present WMIP options and consequences to persons who do not speak English, especially Russians?

***Answer*:** The Client Education subcommittee, which includes volunteers from the community, DSHS staff and the contractor, will help design and review client education materials to explain the process. DSHS is targeting July 2004 as the date in which to begin formal meetings with potential WMIP clients, which allows four months of education before enrollment begins. Language fields are collected through the Community Service Offices, and it is known that Russian, Vietnamese and Korean are the three highest non-English speaking populations who are eligible to be enrolled in WMIP.

DSHS is open to suggestions on methods already used for client education. The WMIP draft contract contains significant requirements around assuring written materials to be understandable to all potential enrollees and that services are provided in a culturally appropriate manner, in accordance with federal requirements.

39. What are the unintended impacts on consumer direct and indirect services? What are the impacts of integration on clients, services providers/networks and staff? What is being done to mitigate the impacts?

Answer: DSHS predicts enrollees will have increased access to care, better coordination of services, and better health outcomes. Research from other states that have implemented integration programs supports those assumptions. Evaluation methods will include evaluation of complaints, encounter data, quality improvement plans and an early warning system. Ongoing quality improvement will be based on results of these monitoring efforts.

40. How will it accomplish Braddock's stated goals: improve client outcomes, cost effectiveness of services and community partnerships? What are the provisions for evaluation of the degree to which these goals are met by WMIP?

Answer: *Better coordination of services across program lines, and guaranteed access to care will help meet the goals of improved client outcomes and cost effectiveness of services. The program evaluation will include components for client outcomes and cost of care measurement.*

42. What savings are anticipated in the first year of the program? $2M? How was that amount calculated? What if there are not savings the first year? Our understanding is that $2 million would need to be added to the state budget if the program was delayed until 2005. Won't that be true if no savings are realized? Where would those funds come from?

Answer: The WMIP rates were calculated with costs savings built in. The cost savings are currently being re-calculated based on the delay in implementing the program.

43. What is the final communication plan (roles, responsibility, timelines, who's on each committee)?

Answer: Please see the Communication Plan. Assigning roles and responsibilities is normally done within a committee, in order to evaluate who has expert knowledge, time,

commitment, and who else may be needed as support. While some committees are fully formed and have roles and responsibilities defined, others are still in the process of being formed and will need more time to develop as a committee.

44. If we participate on the community committee, how do we preserve our ability to report independently to legislature in September?

Answer: Committee participation does not abrogate any rights a Washington State citizen or group of citizens have in writing to the legislature with their concerns or dissent. Signing a committee charter that has a specific set of goals and objectives means you are supportive of those agreed upon goals and objectives and work towards achieving them. It does not prohibit committee members or others from voicing concerns once the results are obtained.

46. What opportunities have those who volunteered to provide input on the enrollment process and material, client education, or evaluation and monitoring of WMIP had?

Answer: Email contact has been made with those stakeholders and internal staff who volunteered to be members of the three sub-committees in order to keep them apprised of WMIP implementation. Only one piece of information has been developed in conjunction with WMIP for client education (see attached) and it was provided to members of the sub-committee for feedback and revisions before finalization.

Before the committees meet in person, the contract must be awarded to the Managed Care Organization who is responsible for implementing the contract to gain access to their feedback. Once the contract is awarded, the committees will begin to meet (either through email or in person if necessary).

50. How will WMIP provide better access?

Answer: Under federal requirements, managed care enrollees are guaranteed access to care, and MCOs must provide quality improvement measures not available to fee-for-service clients.

51. How will it be evaluated? .

Answer*:* A draft evaluation plan has been posted on the WMIP Web page at http://maa.dshs.wa.gov/mip

52. What if more clients opt out? Will dollars follow them? February 2004 Q&A indicates expansion to other counties to obtain the 6,000 level, if necessary. When would that happen? Which other counties would be affected (Skagit, King?). Are those counties aware of that?

Answer: Yes, dollars will follow clients who opt out of the program. DSHS has expressed willingness to consider expansion of this program at a later date. No timeline or plan has been discussed to date.

53. Due to "economies of scale," will the following no longer be available?

- **Snohomish Evaluation & Treatment Facility**
- **Crisis phone line**
- **Greenhouse**
- **Aurora House**
- **Haven House**
- **Adult crisis beds**
- **Representative payee services**
- **Satellite adult extended care program sites in Smokey Point, City of Snohomish, Edmonds**

Answer: These resources will continue to be available.

54. What mitigation will be available to address even short-term disrupted or discontinued services to our Medicaid eligible adults?

Answer: The Care Coordination staff will work with enrollees to ensure continuity of care.

55. Will WMIP be based on the Guiding Principles for Integration adopted by Washington Community Mental Health Council on 12/5/02?

Answer: WMIP is not based on the Guiding Principles for Integration, as we did not receive them until after the RFP had been developed and issued; however, we feel that the Guiding Principles are a valuable addition to the program and have forwarded them to the WMIP bidder.

56. If a client does not opt out at first, will they be able to later? The February 2004 Q&A from DSHS indicates as long as WMIP is voluntary, clients will not be locked in. How long will it be voluntary?

***Answer*:** This is a voluntary program. This means clients may enroll and disenroll without a reason. We do not know at this time how long the program will be voluntary, but in any event, our MAA managed care programs do not "lock in" enrollees – there are always provisions for disenrollment from managed care, although if the program is made mandatory, enrollees may have to meet certain criteria in order to disenroll from the program. As for other managed care plans, disenrollment criteria would meet federal requirements.

57. Regarding evaluation design, did DSHS release a design for stakeholder comment in March, as committed to in the February 2004 Q&A?

Answer: DSHS is seeking grant funding on the proposed evaluation, which has been attached and can now be shared with the public. This evaluation is still a draft until funding is approved.

58. Will WMIP preserve continuity of care for enrollees who have long-term relationships with providers in existing MH/CD provider networks? To what extent will they be impacted? February 2004 Q&A-"Clients who are happy with their current medical provider will not have to switch: if their doctor is not in the health plan, they can choose not to be involved with WMIP."

Answer: Yes, DSHS strives to preserve continuity of care where ever possible. Potential enrollees who have established relationships with providers, whether for medical, mental health or chemical dependency treatment, can decline enrollment in the program.

60. Lack of access to physicians was the stated reason for WMIP. The 1/30/04 fact sheet guarantees clients a doctor. The reason primary care physicians do not take Medicaid/Medicare is because the current fees are low. How does your proposal solve this situation when physician fees will be reduced another 5%? How will it get medical doctors to accept patients they won't accept now, without increasing the fee? If you add in corporate profit of 5-10% then physician cuts are running between 10-15%. How will further cuts in the fee structure enhance access to physician care? Where do those dollars come from? Will this be the same source as administration costs of up to 15%, as indicated in February 2004 Q&A, "The money comes from cost savings related to reducing unnecessary services, such as emergency room use, avoidable hospital stays, eliminated duplicate prescription drug use, etc." When will savings be realized? Where will funding come from if there are no savings?

Answer: While is it true that physicians are reducing the number of Medicaid clients they will see, managed care presents a bit different picture for providers than the fee for service system. An MCO consists of a network of providers, including both primary care and specialty care, so there is somewhere for a primary provider to refer an enrollee who needs specialty care. A complaint we have heard from Snohomish county specialty providers is that they do not like to see Medicaid clients because many of them don't have a primary care provider, and there is little coordination of services. Since the primary component of WMIP is "one stop shopping" for coordination and access to care, we think that providers will be willing to trade higher reimbursement for the assurance of a provider network and better coordinated services. There will be the added advantage of having mental health and chemical dependency providers in the network as well. We expect the vast majority of medical savings to result from reduced ER and hospital inpatient use.

62. We would like to request a copy of the proposal that Molina (the only apparent bidder) submitted.

Answer: It is DSHS policy to not release RFP responses until after the contract has been awarded. Molina Healthcare of Washington will be happy to meet with the Community Advisory Committee prior to project implementation to discuss concerns and solutions.

64. What assurance do we have that our comments, concerns and questions will be respectfully received and acted upon?

Answer: Community involvement, guidance and support have been goals of the Washington Medicaid Integration Partnership from its inception. The integration initiative in the Department of Social and Health Services was launched by our Secretary, Dennis Braddock, with the admonition that it focus on clients' needs and community participation, not on the bureaucracy's convenience. WMIP is only one facet of a new realization often voiced by Secretary Braddock, to the point that the state's social service agency can no longer function as the "mother ship" for all assistance programs. In this era of scarce resources, we must aggressively solicit community participation and join with community partners who are closer to those clients' needs and overall circumstances, who can speak clearly in their behalf and who can help us improve the quality of our programs at the same time they become more cost-effective. In the specific WMIP project in Snohomish County, community members have already had an impact on planning and implementation, and they are helping set up a process to continue their advisory role. Both the DSHS Implementation Committee and legislators have directed the project team to set a high priority on community perspectives and feedback, and DSHS staff from the first community meetings earlier this year have reiterated the team's interest in forming a closer working relationship with providers, stakeholders and clients.